SATURDAY, APRIL 11, 1874.

ORIGINAL COMMUNICATIONS.

FETID CORYZA.

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(Continued from page 419.)

TREATMENT.

THE treatment of a case of fetid coryza will depend upon its nature. When due to the presence of a foreign body, a rhinolith, or a morbid growth, the removal of the exciting cause will cure the discharge. In cases with constitutional taint, systemic treatment is required. The treatment of this condition, in fact, is simpler in principle than in practice; but it is always tedious, and often unsatisfactory. Palliation of the severer symptoms and diminution of the fetor can almost always be effected, but a thorough cure often requires months of persistent treatment; in some instances seeming almost unattainable, and in others, quite so. When the larger bones are diseased, and it is impossible to get access to them, the condition will continue for years; dead bone being exfoliated splinter by splinter, and fresh involvements becoming new sources of evil as older ones are undergoing amelioration.

In scrofulous cases we can endeavor to improve the tone of the constitution by resort to systemic remedies, such as cod-liver oil, quinine, and iron, the preparations of iodine, arsenic, and so on; and we may thus repress increase in the malady, even if we fail in restraining it. The administration of cubebs, preferably, in my own practice, in doses of fifteen to twenty drops, or more, of the oleoresin on sugar, after meals, will sometimes diminish the copiousness of the secretions to a certain extent, and modify their character by the local influence of the drug in its elimination through the mucous membrane of the nasal tract.

The decidedly syphilitic cases, when not so far advanced as to be irremediable, are much more manageable under systemic medication than are the idiopathic and scrofulous cases. Here small doses of the bichloride of mercury, with the free use of the iodide of potassium, are just as serviceable as in other forms of constitutional syphilis, especially if the general vigor of the patient has not been greatly impaired. If the general health is poor, a generous allowance of nutritious diet, assisted by a tonic course of treatment, will be necessary before beneficial results can be expected from specific remedies.

All forms of fetid coryza require local treatment. The parts should be frequently cleansed, and topical remedies assiduously applied. Without preliminary cleansing, local remedies are of little avail: they become entangled with the secretions to a certain extent, and cannot exert that good effect upon the parts which they exercise when applied upon a clean surface.

As mentioned in connection with cleansing the parts preparatory to examination, we use for this purpose the nasal syringe, applied anteriorly and posteriorly, and the continuous nasal douche; employing the medicinal articles already enumerated. These ablutions are by no means to be neglected, but should be attended to as punctually and as scrupulously as the patient attends to other wants of nature.

The local applications for remedial purposes consist of solutions, powders, vapors, and unguents, brought in contact with the parts by suitable appliances. When ulcerated surfaces can be reached by instruments introduced within the nostrils or behind the palate, they should be regularly touched by the sponge, cotton wad, or hair pencil, loaded with a solution of nitrate of silver, sulphate of copper or of zinc, carbolic acid, chromic, nitric, or muriatic acid, or the acid nitrate of mercury, as the case may seem to demand. Dead bone, where accessible, should be removed by the forceps, assisted, if need be, by the knife or scissors. Too much force should not be exerted in the endeavor to remove dead bone. It is better practice often to use frequent traction from side to side with forceps, in a sort of dislodging motion, so as to loosen the pieces of dead bone, and thus gradually render them sufficiently movable to be extracted without much physical effort. If the bone is too large for removal through the nostril in mass, it may be crushed between the blades of strong forceps, or divided by cutting-pliers, and be extracted piecemeal. In many instances the dead bone may be removed through the mouth by means of curved forceps passed up behind the palate.

The contact of the opposing surfaces of mucous membrane can often be overcome by the daily interposition, for an hour or more at a time, of strips of compressed sponge, or of tubes of laminaria; mechanical appliances which compress the parts as they imbibe moisture from the secretions, thereby favoring absorption of the products of submucous infiltration. Where hypertrophied or exuberant mucous membrane exists, and where internal compression is insufficient to enlarge the passage for the free ingress and egress of air and the free discharge of the secretions, it is good practice to twist off portions of the membrane with delicate forceps, so that cicatrization of the irregular edges of the wound may enlarge the passage. The free bleeding accompanying this procedure exerts a salutary influence upon the parts; and though the operation is very painful, it is so efficient in its relief that the patient will readily submit to it again and again, for the sake of the ease it affords in respiration afterwards.

The solutions used by douche or injection may contain chlorate of potassa, alum, creasote, or carbolic acid, permanganate of potassa, chloride of lime, or similar substances, which, in addition to their local action on the parts, tend to control fetor. Or we may use special injections or sprays of nitrate of silver, sulphate of zinc and of copper, the sulphocarbolates of zinc or lime, bichloride or iodide of

mercury, chloride of zinc, chloride of lime, and the like. These injections should be employed at least twice a day, night and morning, and, where practicable, three and even four times a day; and they should always be preceded by the use of the douche for cleansing-purposes. They should be used in weak dilution at first,—say two or three grains to the ounce,—and be gradually increased in strength as tolerance of them is manifested; care being taken that none of the solution is swallowed by the patient, on the one hand, and that too free use of remedies which act promptly on the system be not made, on the other; for the nasal mucous membrane readily absorbs certain remedies, and the proximity of the olfactory filaments to the nervous centre favors the systemic effect of others. This latter fact is often utilized to subdue the pain in the frontal region, by the local application of an ointment containing three or four grains of morphia, or one or two of the extract of stramonium, to the ounce; not more than the volume of a pea being used at a time.

A solution of the chloride of lime was used in this city, with great success, by Prof. Horner, who injected each nostril twice a day with a solution containing a teaspoonful of the chloride of lime in a wineglassful of water. This practice is not much in use to-day, but it deserves to be. A somewhat similar formula, from which I have sometimes obtained very satisfactory results, contains from thirty to sixty grains of the chloride of lime to the ounce of the decoction of krameria; of which two or three drachms, or more, diluted with an equal quantity of water, are injected into the nostrils night and morning, immediately after the use of the douche. Sometimes the parts will not bear a solution of this strength, and it must be diluted accordingly. When the remedy excoriates the external tissues, as it will do sometimes, its use must be suspended or its strength reduced, as may seem most judicious. Perhaps a preliminary coating with collodion will prevent this excoriation, but I have never tried it.

Glycerin is sometimes of great service as an injection, particularly in scrofulous cases. Being bland and unirritating, its affinity for moisture of all kinds facilitates the separation and removal of the secretions, inspissated crusts, and detached fragments of dead bone. The addition of iodine, in the proportion of a grain or two to the ounce of glycerin, is sometimes advantageous.

Prof. Trousseau relied greatly upon certain medicated powders to be snuffed up by the patient twice or thrice a day, after having cleansed the nostrils as thoroughly as possible. His principal formulæ were calomel, a drachm to the ounce of sugar, and red precipitate, forty grains to the ounce of sugar; their use being regulated in accordance with the irritation produced. Another favorite powder, with which he was very successful, was composed of bismuth rubbed up with equal parts of Venetian talc, and this, on account of its innocuousness, was used as freely as was desired.

Camphor, tannin, cubebs, and other substances, separately or in combination, have been used in a similar manner; some practitioners mixing them with two or three times their bulk of Scotch or Welsh snuff. Various mechanical appliances are in use for the purpose of injecting the powders upon the parts.

Citrine and other ointments, more or less diluted, are sometimes used locally after thorough cleansing; being applied to the parts by the little finger, a hair pencil, or a cotton wad on the end of a wire.

The principal remedies used in the form of vapor are preparations of mercury, evaporated over a spirit-lamp, the fumes from which are drawn by inspiratory effort through the nostrils. The fumes of muriate of ammonia from the heated salt itself, or in a nascent state from commingling of the vapors of muriatic acid and strong aqua ammoniæ, are also used a great deal in the scrofulous cases, both for local and constitutional effects.

With all these resources at command, we are able to improve the condition of patients affected with fetid coryza, and place them under the most favorable conditions for the cure of whatever affection has given origin to this loathsome catarrh.

CAN "NUTRITIOUS ENEMATA" BE DIGESTED AND ASSIMILATED?

BY G. TROUP MAXWELL, M.D.,
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THIS article, or its material points, was published in the Savannah (Ga.) *Journal of Medicine*, November, 1866. It was so badly printed, and contained so many typographical errors, as to be scarcely intelligible to myself, and for that reason I republish it in the *Medical Times*.

The question whether food, in the form of "nutritious enemata," injected into the rectum, can be digested and assimilated in the large intestines, is one of not merely speculative interest, but involves, besides, points of practical importance; for the speedy, successful treatment of most of the lesions of the stomach and small intestines and of their glandular auxiliaries in the process of digestion may be much more easily accomplished when, in support of the judicious application of appropriate remedies, absolute rest from the performance of their function as digestive organs can be enforced.

I seriously doubt the efficacy of nutritious enemata, and in discussing the question shall endeavor to maintain—1, *that digestion is a necessary preliminary to assimilation;* 2, that digestion is begun and completed in that part of the alimentary canal which is above the ileo-cæcal valve; and 3, that the large intestines are not digestive organs, and neither do nor can perform the function of digestion.

That digestion is a necessary prerequisite to assimilation or nutrition, is a postulate which will require little or no argument to prove, as no one will seriously question or deny it. The universality of the existence of organs suitable for the performance of that function in animals from the lowest to the highest in the scale of being, is conclusive evi-

dence upon the point. An important distinction between the vegetable and animal kingdoms is that, whilst the former find their food consisting of inorganic elements in a fluid or gaseous state, in simple form, ready for absorption, the latter receive theirs as compound organized substances, which must be reduced, liquefied, and vitalized, and thus prepared for assimilation. To effect this result, organs more or less complex, according to the nature of the food to be acted upon, with certain secretions which are common to all animals, are provided. In the Graminivora a large and more complex mechanism is found, the function of which is to extract from the large bulk of food received into it the comparatively small amount of nutriment it contains; whilst in the Carnivora, the proportion of nutritious ingredients of the food being much larger, and the reduction and liquefaction of it much more easily effected, a set of organs proportionately small and simple is found. Whether the organs of digestion be large and complicated, or small and simple, certain secretions, known to be digestive fluids, are always present, and their essential importance in the digestive process has been demonstrated.

In support of the view that digestion is completed when the food, in its passage through the alimentary canal, reaches the ileo-cæcal valve, there is no lack of testimony. Dr. Dalton, in his great work on Physiology, says, "Digestion of the food is not a simple process, but is made up of several different processes, which commence necessarily in different portions of the alimentary canal. In the first place, the food is subjected to the physical operation of mastication and ensalivation. Reduced to a soft pulp and mixed abundantly with saliva, it passes secondarily into the stomach; here it excites the secretion of gastric juice, by the influence of which its chemical transformation and solution are commenced. If the meal consists wholly or partially of muscular flesh, the first effect of the gastric juice is to dissolve the intervening cellular substance, by which the tissue is disintegrated and the muscular fibres themselves become swollen and softened by the imbibition of the gastric fluid, and are finally disintegrated and liquefied. In the small intestines the pancreatic and intestinal juices convert the starchy ingredients into sugar, and break up the fatty matters into a fine emulsion, by which they are converted into chyle. Although the separate actions of these digestive fluids commence, however, at different points of the alimentary canal, they afterwards go on simultaneously in the small intestines. *Throughout the small intestines the secretions are intended exclusively or mainly to act upon the food, to liquefy or disintegrate and to prepare it for absorption.* But below the situation of the ileo-cæcal valve and *throughout the large intestines the contents of the alimentary canal exhibit a different appearance, and are distinct in their color, odor, and consistency.* This portion of the contents, *or fæces*, is not composed for the most part of undigested remains of the food, but consists principally of animal substances *excreted by the mucous membrane of the large intestines.*" Says Dr. Flint, "It is now almost universally admitted that *the digestion of all classes of alimentary substances is completed either in the stomach or the small intestines.*" Magendie emphatically declares, "*I conceive that digestion is completed effectually without the large intestines taking any part in it.*" Professor Martyn Payne, in his voluminous "Institutes of Medicine," ascribes to the gastric juice "the principal agency in the assimilative process," and imputes to the saliva, bile, and pancreatic juice, auxiliary powers of a "problematical" character.

Digestion consists in the conversion of food, first into chyme, and next into chyle; that accomplished, digestion is "effectually completed." Chyme is produced in the stomach by the gastric juice; chyle is formed in the small intestines by the operation of the pancreatic fluid, bile, and intestinal juices. And Dunglison declares that "when the food has attained the lower part of the ileum the process of chylification is accomplished."

In proof of my last point,—that, perhaps, of chief interest and importance in this discussion,—the evidence is drawn both from the anatomical structure of the large intestines, and from the known facts which have been developed by physiologists as to their real functions. In the mucous membrane of the stomach are myriads of follicles, which secrete the most potent of the digestive fluids,—the gastric juice. In the small intestines are the pancreatic fluid and bile, the secretions of large glands, whose ducts terminate in the first division of the intestines, and the intestinal juices, which are the products of glands lying in the mucous membrane of the intestines, which decrease in number as the large intestines are approached. But in the large intestines there is nothing of the kind. *From the ileo-cæcal valve to the anus there is not a gland or a membrane that secretes a digestive fluid.* This is the testimony, I believe, of every anatomist who has written upon the subject.

In the stomach and small intestines food is to be digested, and there we find *secretions* or digestive fluids, fitted to disintegrate and liquefy the food, and thus to prepare it for absorption and assimilation; in the large intestines, on the contrary, we do not find *secretions*, but animal substances which are "*excreted* by the mucous membrane." Nature has provided glands, which *secrete* digestive fluids in and near the portion of the alimentary canal which is above the ileo-cæcal valve, while she has denied them to the portion which is below that valve. Above are *secretions*; below, *excretions*.

Speaking of the large intestine, Magendie says, "It fulfils sufficiently well the office of a *reservoir*, where is deposited for a time the residue of the chemical operations of digestion, to be afterwards expelled."

And Dunglison says, "The large intestine acts as a reservoir and *excretory canal for the fæces*." Flint characterizes "the process of digestion which takes place in the large intestine as *unimportant*," and declares that "hardly anything but water is absorbed by its lining membrane." And Dalton, as we have seen, forcibly contrasts the appearance of the contents

of the small and large intestines,—their "color, odor, and consistency," calling the latter "*fæces or excrementitious matter.*" Thus we see that the function of the large intestines is neither to commence nor to complete the digestion of food,—the anatomy of the organs forbidding the exercise of any such function, and physiology testifying to the same fact.

Now, I think I may claim to have established irrefutably—1, that the complex process of digestion is *an absolutely necessary preliminary* to assimilation; 2, that this result is reached in the completion of chylification, before the contents of the alimentary canal pass the ileo-cæcal valve; and 3, that the large intestines do not and cannot perform the function of digestion, but that they act as a "reservoir" simply,—an "excretory canal" for the fæces, whence they are after a time expelled.

Now, if these propositions are true, where is the sense of using so-called "nutritious enemata"? What efficacy can be derived from alimentary substances injected into the large intestines, *unless they can be digested?*

John Hunter called digestion "a species of regeneration." It certainly is not simply a solvent process. Food is not only liquefied, but it is *vitalized* also. And if alimentary substances are injected into the large intestines, which have no power to *digest* them, they remain inert and dead, as much so as if they were put into a jug.

But, it is asked, may not liquids holding in suspension or solution the ingredients of food be absorbed by the large intestines, and subserve the purpose of nourishing the body? The answer is positive and unequivocal, No; it is only "*by admixture with the gastric juice and the intestinal secretions,*" says Dr. Dalton, that "*liquids holding in suspension the immediate principles of animals and vegetables become modified and rendered fit for assimilation.*" Food injected into the large intestine cannot, therefore, be assimilated, because the *necessary* "admixture with the gastric juice and intestinal secretions" *cannot take place there.*

Nor do the experiments of Dr. W. O. Leube, of Erlangen (*Med. Record*, from *Deutches Archiv für Klin. Med.*), disprove or militate against the positions of this article, but, on the contrary, they confirm them; for by mixing pancreas with beef to effect *artificial digestion*, he assents to the proposition *that digestion is an essential prerequisite to assimilation;* and his endeavor thus "to transfer to the large intestines a part of the digestive processes which normally take place in the small intestine" is equally a confession "that the large intestines are not digestive organs," etc. Digestion would be as thoroughly effected by the method of Dr. Leube in a retort as in the large intestines.

The error of supposing that food could be digested in the large intestines, when injected *per anum*, arose, undoubtedly, from confounding the phenomena of *absorption* with those of *digestion*, at a time when the latter were not so well understood as they have since become; and the error has been persisted in from want of due reflection. But absorption is a physical act, purely, whilst digestion is a complex process, both physical and vital.

In the summer or fall of 1856 I wrote a letter to the learned and distinguished Dr. Beuriet-Dowler, then editor of the *New Orleans Medical and Surgical Journal*, intimating a doubt as to the efficacy of nutritious enemata, and requesting him to discuss the question in that journal; I hoped to have the subject illustrated by his great research and enlightened views. In his reply, however, he published several lengthy extracts from European writers to prove that *medicines* injected into the rectum are absorbed, and produce their usual desired effects. Mistaking the object I had in view, and the direction I hoped to give to his investigations, he set about proving what I have never dreamed of questioning, and what every tyro in the profession knows and practises. *But medicines are not acted upon by the digestive fluids as food is.* They do not produce their remedial effects by being digested or assimilated. Whilst *food* must be liquefied and vitalized by admixture with the gastric juice and the intestinal secretions, and thus rendered fit for assimilation, *medicines* are absorbed unchanged, or in new combinations, and circulate in the vessels, until, like all extraneous matter, they are eliminated. *Medicines are not digested.*

Most medicines are poisons, if taken in sufficient quantity; and whether the amount taken into the stomach be less or greater does not affect the question of the influence upon them of the digestive fluids. Now, if a person is known or suspected to have had poison administered to him, either by mistake or designedly, a chemist does not hesitate to determine the question of his having been the victim of a criminal purpose or of an unfortunate blunder. Indeed, he not only determines the fact of poisoning, but he reveals the character of the agent employed. However subtle the instrument of death, or slow and gradual the process of introducing it, the skilful chemist, with his sensitive reagents intelligently manipulated, will disclose the facts of the case. The poison will be discovered in some organ remote from the stomach; perhaps in the very form in which it was swallowed. Although absorbed, it was not digested, and therefore could not be assimilated. Arsenic, strychnia, antimony, opium, etc., etc., have each—to the praise of a noble science, which has thus become the handmaid of justice, be it said—been thus detected.

Food, on the other hand, unlike medicines and poisons, is not only dissolved, but is digested, before it is absorbed. By admixture with the digestive fluids, animal and vegetable substances are reduced to a homogeneous, undistinguishable mass, when all the chemists in the world would find it an impossible task to determine the form or nature of the food which had been thus changed in its physical, chemical, and vital properties.

Some plausibility has been given to the notion that "nutritious enemata" have proved efficacious in sustaining failing strength, by the fact that persons to whom they have been administered, when food could not be received *per vias naturales*, have lived for several weeks. But cases must have occurred in the practice of many physicians where life has been preserved, apparently miraculously,

and no food has been taken in any way. I have in my mind the case of a child, seven or eight years of age, who, in 1870, lived through an attack of typhoid fever which lasted *ten weeks*, who did not allow *a drop of anything* to be received into her body for at least two-thirds of that time. Mr. S. F. Shallcross, President of the Levy Court of New Castle County, Delaware, has communicated to me the fact that his father, who is eighty-three years old, was, in the winter of 1871–72, sick with "*debility*," and that *for sixty-three days, or nine weeks*, during which he nursed his father, *his only nourishment* was "about two tablespoonfuls of brandy, and the same quantity of gum-water, in twenty-four hours." Dr. Burns, of Frankfort, attended the case. Had nutritious enemata been administered in either case, how naturally the remarkable tenacity of life would have been attributed to their nourishing and sustaining powers!

After long and mature reflection upon this subject, I am settled in the conviction that the use of "nutritious enemata," in our day, is one of the many illustrations which could be furnished of the fact that clinical practice does not keep pace with the advances of physiology and other correlative sciences.

NEW CASTLE, DELAWARE, March, 1874.

A SUCCESSFUL CASE OF TRACHEOTOMY FOR CROUP.

Read before the Philadelphia County Medical Society, Dec. 24, 1873.

BY M. O'HARA, M.D.

I WAS called, on Wednesday night, November 19, to see Fannie P., aged 3 years and 8 months, a healthy child suffering with all the symptoms, according to books and teaching, of pseudo-membranous croup. She went to bed well, and arose Monday morning with croup and catarrh; to the latter she had been prone since an attack of measles, a year or so previously. She had never had an attack of croup before, and received home-treatment, in spite of which she steadily grew worse.

There was, at my visit, fever, croupy cough, catarrhal sounds in right bronchus, but no membranous deposit was visible in the throat. The tonsils and arches of the palate were congested and swollen. There was, at times, a spasmodic closure of the laryngeal orifice, but also a gradual and persistent narrowing. The larynx was tender. Her appetite was good, and she took nourishment well. The cough was hoarse, somewhat suppressed. Respiration was audible, and becoming more difficult. I thought surgical aid was required, and stated so to her parents, basing my opinion on the rapidly progressive apnœa and the commencing exhaustion. I had lost a case similar to this, and the temptation was strong to have tracheotomy performed at once. I, nevertheless, wished to try in full all the resources of medical art,—steaming with lime-bath, emetics, hot sponging to the larynx, saturation with alkalies; these relieved somewhat the urgency of the symptoms during Thursday. Thursday night things looked badly, and Friday morning an operation was demanded.

Drs. Carroll, J. H. Grove, and Dr. O'Neill agreed, at 9 P.M., that an immediate operation was necessary to save life; but the parents still refused, and treatment was continued during the night. Mercurials were given, and the gums touched. At 8 o'clock on Saturday morning, November 22, the operation was skilfully performed by Dr. Grove. Immediate relief followed, the tube was introduced, and respiration was performed naturally. Anæsthesia was effected by chloroform and ether. Their use seemed to me questionable, in the already paralyzed condition of the breathing apparatus. As chloroform, in a recent coroner's jury in Boston, has been denounced, we ought at least to use only ether to be safe from law-suits. There was a moment of syncope, which seemed like death, but the rapidity of Dr. Grove in letting air into the lungs saved life.

The father, constantly present, day and night, to nurse, was taught to remove the tube for cleansing. The inner tube could not be used, as air sufficient could not be carried with it in place. The child was placed in an apartment partitioned off by hanging counterpanes. A saucepan also of slaking lime was kept in the room, and steam from boiling clothes in a wash-boiler, the latter a practical suggestion of Dr. Cohen, worthy of recollection. The patient was kept upon veratrum viride and citrate of potash, with quinine. In consequence of the ten hours' delay from night until morning asked by the parents, the dyspnœa had steadily increased, and at each inspiratory effort there was recession of the base of the thorax, a sulcus around the chest; in fact, just before the operation the recession of the lower part of the sternum and epigastrium might be called almost permanent. There was some hissing laryngeal stridor, and auscultation and percussion showed that collapse of the lower part of the lung had taken place, and this was not observed the night before. There was also scattered lobular condensation or congestion of the lung. Treatment was instituted to prevent pneumonia and bronchitis. The child did well until the night of the 23d, when it showed a feverish oppressed condition, with dyspnœa and exhaustion. The symptoms were alarming, and Dr. Grove was summoned. The tube was at once removed, and found to be sealed with a cement-like substance almost completely. This was removed and the tube replaced, when respiration went on naturally, and the symptoms were relieved. Care was taken to cleanse the tube thoroughly by passing through it a piece of tape.

Dr. Pancoast uses no canula in his cases, but makes an opening by excision, which he keeps free with a piece of lead wire. If it were possible to do this in all cases it would be safer. The tube demands great attention, and in this case required to be retained a month.

The wound kept healthy, sweet oil being the only dressing. No gauze was used over the orifice, but the use of vapor was continued the whole time. No false membrane could be detected. Only liquid food was allowed, and hot poultices were kept constantly applied to the chest.

November 24.—Chest-symptoms are better. Poultices continued. Diaphoretics and quinine are now given. No air as yet passing through the larynx.

November 25.—Up to this time the larynx has been completely occluded, but to-night some air comes through, accompanied by the old croupy sound. The patient took bread to-day: the crumbs, however, produced irritation and choking, which was relieved by a drink of water. The discharge through the tube is less, thinner, and can pass through by the ordinary expiratory effort, though at times it accumulates below the tube and must be removed. Crepitation and bronchial râles still give evidence of some lung-trouble.

November 29.—The seventh day after the operation; the patient weak, and has no appetite. Suspended quinia and fever-mixture, and ordered vegetable tonics and wine whey. The wound is very contractile; tube

has to be replaced rapidly. There is always an increasing vent in the larynx from cough when she drinks fluids. Removed the canula, and replaced it with a larger double tube.

November 30.—Laryngoscope shows the absence of swelling and membrane.

December 1.—Some fever; erythematous redness of one cheek, bronchial râles and congestion of the lower part of the left lung. Ordered magnesia; resumed poultices and diaphoretics.

December 2.—Patient is better; takes eggs, milk, corn starch, oyster soup, etc. Ordered castor oil. On this, the twelfth day after the operation, by closing the orifice, she can articulate for the first time, but the exertion soon fatigues her. Takes two ounces of wine daily. Suspended veratrum viride and diaphoretics; continued tonics.

December 3.—Catarrhal symptoms increased. Had a poor night. Considerable vent in the larynx. Articulates, but with greater croupy sound than yesterday. Much thick muco-purulent matter collects below the tube. From this time the patient did well. On December 16, the twenty-fourth day after the operation, she was practically well. Examination with the laryngoscope showed, as always before, no sign of membrane.

Remarks.—I have called this pseudo-membranous croup, not because we saw no membrane, but because all authorities, by their detail of symptoms, would force us to class it under that head. I have consulted Meigs and Pepper, Reynolds, Aitken, Wood, etc.: they are very diffuse on the subject, but confused. Most of them, as Aitken, define it as a specific disease with exudation on mucous membranes, indicated by alteration of respiration, cough, hoarseness, and laryngeal spasm, to terminate in suffocation or exhaustion. He recommends tracheotomy early, if respiration is so impeded that the demand for oxygen is only satisfied by difficult and forced respiration, or if the patient is becoming exhausted, and not to wait for asphyxiation. He speaks of an insidious form, coming on more slowly, with weariness, weakness, and restlessness, anxious startings out of short slumbers, loss of consciousness, pallor of face, approaching to œdema; in this kind of croup, delay must especially be avoided. The case just narrated had this train of symptoms. Meigs makes three kinds of laryngitis: catarrhal without glottic spasms, spasmodic simple laryngitis, and pseudo-membranous, including in this diphtheria. He makes a grave form of the simple laryngitis, which ensues in death. He is not very clear in distinguishing this from pseudo-membranous, nor, in fact, can it be distinguished. The only certain sign is the presence of false membrane. In the case just narrated there was no membrane seen; yet authors tell us that this is no proof that it is a case of simple inflammation. Meigs and Pepper say that in membranous croup there is a slow, steady, unrelenting progress of the symptoms. This was the case in this patient, together with altered and suppressed voice, dyspnœa, and stridor. She had mainly a continuous increasing obstruction to the entrance of air in the larynx, the cause of which remained until the thirteenth day after the operation, during which time it seemed to be, at least for a few days, completely closed. Again, Flint and Jacoby give, as a test, that in membranous croup dyspnœa exists both in inspiration and in expiration; in catarrhal croup it is chiefly in inspiration. This case also bears this test, and we are constrained to call it pseudo-membranous, although the existence of membrane was extremely doubtful. In the typical case of recovery under Prof. Meigs's care there was abundance of membrane visible, and recovery complete on the ninth day. Recession of the sternum and epigastrium during inspiration and a deep sulcus around the base of the chest are given by the books as a mark of pseudo-membranous croup. I think this should be laid down as an indication for tracheotomy, but as no evidence of membranous deposit. Any kind of obstruction of the larynx will produce this from atmospheric pressure on the outside of the chest, the counterbalancing pressure within being removed. Auscultation is not to be relied upon, though it was of great service in this case. Too many mistakes have been made by experienced auscultators, where pseudo-membranous croup was diagnosed, while post-mortem examination showed nothing to account for death. Hartshorne, in his "Essentials of Practice," is clearer than others, in stating that the pathological elements of croup are spasm, congestion, or hyperæmia, and inflammation, either ordinary or diphtheritic. A purely inflammatory case without spasm is very rare. Pseudo-membranous does not differ from inflammatory, of which it is only a grade or termination. *Tracheotomy*, of itself, is attended with very little danger, and should be performed oftener and earlier. There is too much prejudice against it at present. When death occurs it is from tissue-alterations, blood-poisoning, etc., and not from the operation. In this case, ten hours' delay, although it was the fifth day, gave us some bad symptoms to contend with after the operation. Many cases of ill success are due to neglect in after-treatment, such as neglect of the tube, blood-poisoning, disease of lung induced by delay. Such cases should be eliminated from statistics, or the statistics thrown to one side altogether. I think the physician criminally negligent who fails to perform the operation if it is in his power. The saving of this child's life brings to me self-satisfaction, though the practical part of the work was performed by Dr. Grove, to whose unremitting kindness, solicitude, and skill I owe so much, and to whom here publicly I wish to render thanks. I also feel indebted to the kindness of Dr. Cohen, who on several occasions endeavored to determine whether this was a case of false-membrane croup or true-membrane croup, or whether it was simply, as Reynolds describes, a case of croup.

BELLADONNA IN INTESTINAL INVAGINATION AND HERNIA.—M. Gallicie (*La France Médicale*), in a paper on belladonna, says it is the special medicament for intestinal invagination, strangulated or not, as also for strangulated hernia. It acts on both the spasmodic and inflammatory elements. In both cases, however applied, its first effect is to alleviate the intensity of pain and to diminish and arrest the vomiting.

NOTES OF HOSPITAL PRACTICE.

BELLEVUE HOSPITAL, NEW YORK.

CLINIC OF PROF. L. A. SAYRE.

FRACTURE OF CLAVICLE.

FRACTURE of clavicle, which this man has, is one of our most common fractures, yet is most difficult of treatment, as is indicated by the endless variety of apparatus suggested for its adjustment and retention. Dr. Paul Eve, of Nashville, Tennessee, has even resorted to cutting down on the fractured ends and wiring them together. In fractures we have one general law of treatment: extension and counter-extension in the proper direction until accurate adjustment, then retention. In these cases, for several years I have used, with marked success, two strips of strong adhesive plaster (Maw's moleskin), without any axillary pads, three or four inches wide, one long enough to surround the arm and go completely around the body, the other to reach from the sound shoulder around the elbow of the fractured side and back, to the place of starting. The first piece is passed around the body below the axillary margin, and is pinned in the form of a loop sufficiently large to prevent strangulation, leaving a portion on the back of the arm encased by plaster. The arm is then drawn *downward* and backward until the clavicular portion of the pectoralis major muscle is put sufficiently on the stretch to overcome the sterno-cleido-mastoid, and thus pull the inner portion of the clavicle down to its level. The plaster is then carried smoothly and completely around the body and pinned to itself on the back, to prevent slipping. This first strip fulfils a double purpose. First, by putting the clavicular portion of the pectoralis major on the stretch, it prevents the clavicle from riding upward; and, second, by acting as a fulcrum at the centre of the arm when the elbow is pressed downward, forward, and inward, it forces the other extremity of the humerus, and with it the shoulder, upward, outward, and backward. It is kept in this position by the second strip, applied as follows: commencing on the point of the shoulder of the sound side, drawing it smoothly diagonally across the back to the elbow of the fractured side, where a slit is made in its middle to receive the olecranon; a soft piece of muslin over the joint of the elbow is of advantage. Before applying the strip my assistant presses the elbow well *forward* and inward, and retains it there while the plaster is continued over the elbow and fore-arm, pressing the latter close to the chest and securing the hand near the opposite nipple, crossing the shoulder at the place of beginning, and there securing by pins. My patient can be well shaken and no displacement occur. If any slack occur it should be taken up at once. I dressed a lawyer in this way who fell near my office at 9 A.M., and he was pleading his case in open court at 11 o'clock. Bandages do not stick, but slip around the body and give no firm support. Never warm the plaster. Sternal dislocations of this bone are also to be treated in this way, with the addition of a third piece of plaster, and a pad over the point of displacement. The strip passes diagonally across the shoulder and body, and its ends are secured to the first piece, or both.

HIP-DISEASE.

Case I.—Girl, 12 years old; hip-disease, with open sinuses; marked deformity; too feeble to walk. Born of healthy parents, and one of a large family of stout children. Fell from stoop five years ago and injured the left hip; confined for two years in an Institution for the Relief of Cripples, in this city, where only constitutional means are used,—bark and mercury: no attempt was ever made by extension to relieve her sufferings or deformity; the head and neck of the femur are destroyed and the acetabulum perforated. Authors term this the stage of luxation, but of my forty-seven cases of exsection I have yet to find one luxated. The capsular ligament is not ruptured, but is displaced,—the edges of the acetabulum having been absorbed by the constant pressure of the end of the femur, which is within the capsular ligament and enlarged acetabulum.

My plan of exsecting the hip-joint is as follows. Take a short, strong knife, send it home to the bone at a point midway between the anterior superior spinous process of the ilium and the top of the trochanter major; carry the knife downwards in a slight curve until you reach a point opposite the trochanter minor, not passing over the centre of the trochanter, but half-way between its centre and outer border,—the incision should be six or eight inches long; boldly divide all tissues and the periosteum, and do not dissect as for hernia. Opposite the trochanter minor divide with a probe-pointed bistoury the periosteum as far around the bone as possible, at right angles to the first incision, and at its lower limit; a knife is used to cut the rotators attached in the digital fossa;—peel off all the periosteum carefully and effectually, from the diseased bone; by adducting the limb slightly, the bone is denuded of periosteum down to the trochanter, where a chain or metacarpal saw divides the shaft; several sections are often needed to reach sound bone; this is done by pushing the ends of the femur, through a slit in the periosteum. In this case two sections are made—the last three inches below the trochanter minor,—when we come to good bone; we then gouge out the diseased bone from the acetabulum, wash out the wound, and fill it with balsam of Peru and oakum, thus allowing more space for new bone, the periosteum being left intact. Never leave the trochanter major; it would plug up our drain-pipe from the diseased acetabulum. Free drainage is essential to success; hence use oakum, and by no means lint or cotton. In this case the head and neck are absorbed, and the trochanter major is rounded off by deposits of new bone, thrown out around the specimen removed; almost a perfect involucrum. Efforts at repair have encased the dead bone, and the patient would have died before its removal by nature; anchylosis existed, due to these new formations attached to the ilium. Place the patient in "wire breeches"—a machine consisting of wire frame, which encloses the body from head to feet, fixing immovably the whole lower half of the body. The sound limb is secured to one leg of the machine,—care being used to stiffen the knee, thus fixing the pelvis,—the lame limb is extended as far as the contracted muscles will allow, and is held by two strips of plaster carried from the ankle to the femur, and secured by a roller; the plaster is brought down around the foot-piece, which works on screws, so that the limb is extended gradually; a roller is then passed over the limb and pelvis, around an arm of the instrument, to act as a perineal band, keeping up constant counter-extension. Pad all points of pressure, and have the anus fit well to the crotchet of the breeches. Now the patient is ready for fresh air; our best results have been those exposed freely out-doors. To test the necessity for dividing contracted tendons or muscles, put the tissues on the stretch, and make point-pressure with the finger: if reflex spasm occur, cut, for the part is contractured; if no spasm result, do not cut, as the part will stretch, it is only contracted. In using extension it must be from the femur; have the plaster come above the knee. London surgeons magnanimously acknowledged their failures in hip-disease to be due to not having their extension from above the knee, which was also frequently the cause of synovitis of the knee-joint.

Case II.—Boy, 13 years; third stage, hip-disease; exsection performed June, 1873. Waxy liver, spleen, and

kidneys, developed during the progress of the disease, with general anasarca and abundant urinary casts, caused us to refuse exsection; but we subsequently operated with the slight hope that there remained enough healthy tissue in his organs to sustain life. The result has been good: the hip is well, and the deformity lessened. A principle has been established by this and other cases: remove the cause of disease consequent upon hip-joint disease or other exhausting trouble, and you have a prospect of good recovery.

Cases III. and IV. illustrate nature's exsections; fearful deformity presented. This young man suffered eleven years with hip-disease; his thigh is scored with sinuses; anchylosis is complete; the whole femur is diseased. I will remove the dead bone at its lower portion,—leaving seven or eight inches' shortening. This serious result could have been avoided by exsection ten years ago. This girl has had twenty sinuses; two are still open, and dead bone can be detected; there is much shortening; the adduction is so great that the inner sinus cannot be well cleaned; anchylosis was feared, but the pain and tenderness to-day, from handling it yesterday, make us safe in concluding that motion, though slight, was made. A long splint from pelvis to foot, with a hinge-joint, and worked by screws attached to a platform on the pelvis, best allowing abduction and rotation of the limb to be made, will overcome this deformity; passive motion will break up the anchylosis. Otto & Reynolds, 64 Chatham Street, are making one. This splint was first used by me, and with perfect success, in 1868, for a like trouble.

Case V.—This young man has taken prizes in skating since I exsected the head and neck of his femur in 1864. (The class unable to tell which limb had been diseased.) The new joint is perfect.

Case VI.—Girl; first stage of hip-disease, advancing into second. Limb slightly abducted; gluteo-femoral crease less marked than its fellow on sound side. Pelvis has assumed an oblique position; natural rotundity of gluteal muscles diminished, knee slightly bent. My rule for the normal standard of position from which comparison is made in forming our diagnosis of this disease is as follows: Place the patient on her back upon a hard surface, limbs parallel to each other, in continuation of long axis of body, spinous processes touching the table, pelvis fixed; draw a line from the sternum over the umbilicus to the pubes; another from one anterior superior process of the ilium to its fellow; the lines will intersect at right angles if the trunk and pelvis bear their normal relations to each other; if no obstruction exist at the joint the leg can be extended perfectly straight, the popliteal space touching the table. The position in which the diseased limb must be held to give comfort to the patient while the sound limb and pelvis are thus fixed, is the deformity indicating the stage of disease. This deformity is due to tension in the joint from effusion and muscular contraction, the result of reflex irritation—or to complete muscular rigidity. Many such cases are treated by mercury, blisters, cod-liver oil to relieve constitutional tendencies; the joint finally abscesses, and dead bone occurs, as seen to-day. In a majority of cases the head and neck of the femur are destroyed; imprisoned dead bone remains to irritate, constantly aggravated by muscular contractions forcing the end of the bone through the diseased acetabulum. All these cases are decidedly benefited by judicious local treatment. Some authors do not support it. Dr. Ashhurst, one of our best critics, says that local treatment is wrong, and expresses the wish that a new Abernethy would arise to revive and recommend general constitutional treatment. I believe and know that the man who can adjust an apparatus to this hip in a way to give perfect comfort to it, and prevent deformity, and permit the child to get out-doors where it can obtain all the reviving and tonic influences of fresh air and sunlight—that man is the true Abernethy. Such treatment is worth more than all other forms combined; worth all Abernethy's potions and pills put together!

T. S. Sumner, M.D.

TRANSLATIONS.

Use of Baths in Typhoid Fever.—The use of cold applications in typhoid fever may be made by means of affusions or of the cold bath.

The first of these are indicated in adynamic cases, accompanied by profound intellectual torpor, etc. They act by exciting, so to speak, the reflex activity of the respiratory and circulatory centres, and dissipate those conditions which depend more upon faulty innervation than upon elevation of temperature.

The cold bath, on the other hand, is indicated where it is desired to subtract from the economy a certain amount of caloric, the augmentation of which might prove fatal to the patient.

Brand, of Stettin, one of the earliest advocates of cold baths in typhoid fever, recommended their use every three hours, day and night, the patient remaining in the bath, which had a temperature of 68° Fahr., twelve minutes.

According to him, it is not sufficient to lower the already augmented temperature; it should not be allowed to become elevated.

The effect of cold baths on a healthy person is only temporarily to lower the temperature, and that to a limited extent. The spasmodic contraction of the peripheral vessels drives the blood to the deep cavities, where loss of heat by radiation is prevented to a certain degree, while its production is at the same time augmented, as the amount of carbonic acid exhaled testifies. Then the period of reaction quickly dissipates the effect of the cold application.

On the contrary, it is comparatively easy to lower the temperature of a fever-patient, and this is done not by moderating combustion, but by increasing waste, an action diametrically opposed to that of quinine and alcohol remedies, which address themselves to the former purpose.

The two results of the action of fever in the economy—rapid waste of tissue and elevation of temperature—have their dangers, and carry with them indications for treatment. In hectic fevers the danger is from waste of tissue, not undue elevation of temperature; here no one thinks of using baths. On the other hand, in acute pyrexia the danger is less from waste of tissue than simple elevation of temperature. The whole group of ataxic and adynamic phenomena occurring in such cases depends, doubtless, upon the pernicious action of an overheated blood on the nervous centres.

It is in these cases that the most important point to be gained is the rapid cooling of the blood,—an indication which hydrotherapy alone can fulfil.

Without doubt the application of cold awakens the reflex activity of the pulmonary vessels, just as it reanimates the cutaneous functions and dissipates passive congestions.

While Brand accepts no contra-indications to the employment of cold, except intestinal perforation, Wünderlich advises baths, warm at first, the temperature of which is gradually lowered by the admixture of cold water, in cases attacked by profuse diarrhœa, albuminuria, heart-troubles, or in the case of pregnant women.

Wünderlich regards intestinal perforation, hemorrhage, and collapse, as contra-indications; we cannot partake of this view in the latter instance, and believe, on the contrary, that immersion baths as well as cold affusions are the best agents to prevent that tendency

to paralysis of the vasculo-respiratory centres which is the primary cause of collapse.

A case recently occurring in our wards illustrates this point. A young girl, attacked by typhoid fever, was found one morning menaced with collapse. The nose and the extremities were cold; the axillary temperature was 96.8° Fahr.; the pulse was thread-like, almost imperceptible. Half an hour after the administration of the cold bath the patient had warmed up, the pulse and temperature were raised, and all traces of collapse had disappeared.

What are the advantages, then, of this treatment which has gained such general acceptance, and which in Germany is employed almost to the exclusion of every other therapeutic resource?

It may be asserted that the administration of several cold baths in twenty-four hours will often control and cut off a febrile movement which to all appearances is likely to be violent and tedious.

While fulfilling the indication of lowering the temperature, this treatment at the same time affects favorably the entire group of symptoms proper to the typhoid pyrexia. The nervous centres are first influenced, the delirium is dissipated, the intellectual torpor disappears, and even, in some cases, the subsultus tendinum and other indications of profound nervous perturbation. The action of the respiratory centres is also favorably modified, inspiration is deeper, softer, and stronger, and the bronchia recover their contractility, throwing off the products of secretion which obstruct them. The circulation of the blood is also improved, the skin becomes soft, tympanites diminishes, and the secretions become more normal.

One single objection may be stated in regard to the use of cold baths in typhoid fever,—namely, that internal hemorrhages are favored thereby.

In 257 cases treated by the cold bath, 18 cases of hemorrhage occurred, or 7 to 100; while by the ordinary treatment, hemorrhage occurs only in 3 to 4 cases per 100. Wünderlich, however, is inclined to doubt that the hemorrhage in these eighteen cases was due to the use of cold baths, since it only came on some hours after their use, when the internal congestion no longer existed. Finally, in none of these cases was the hemorrhage serious, and they all resulted favorably. —*Bull. Gén. de Thérap.* (Prof. Béhier). A. V. H.

Operation for Artificial Vagina.—Prof. Dolbeau relates, in the *Bull. Gén. de Thérapeutique* for February 15, 1874, a case of congenital absence of the vagina occurring in a girl of twelve who came under his care in the Hôtel-Dieu in 1866. Examination showed the external organs apparently normal, the uterus in position, but no connecting canal. As the child had been suffering for some weeks previous from acute abdominal pains occurring at intervals, an operation was decided upon and was successfully carried out, whereby an artificial vagina was created. At the completion of the operation some dark clots were evacuated from a sort of pouch around the neck of the uterus. By the introduction of the fingers every other day, and later by the use of a metallic bougie when it was found there was danger of its becoming sealed, the canal was kept patulous. Subsequently, this was abandoned, menstruation became regularly established, and six years later the girl was married. Dr. Dolbeau some time afterwards delivered her of a seven months' child, born dead, but of quite large size. The delivery was easily accomplished, excepting that a cicatricial ring, which had to be divided, was found in the upper third of the vagina. The woman's health remained good up to the date of the report.

Dr. Dolbeau concludes that the artificial vagina created in the pre-rectal cellular tissue became capable of assuming the characters of a mucous cylinder, that coitus was easy, that fecundation was the result, and, finally, that accouchement presented no serious difficulties. A. V. H.

Curative Effect of Erysipelas upon Syphilis.—M. Mauriac believes that, under certain circumstances, erysipelas may exercise a more or less curative effect upon certain of the lesions of syphilis. In support of this view he brings forward two cases, in the first of which the patient, when first brought under his notice, presented mucous patches upon the tonsils, palate, lips, etc.

After undergoing cauterization of these patches, the patient was attacked by erysipelas, which invaded the entire face. Within five days the syphilitic lesions had entirely disappeared.

In a second case, which presented not only mucous patches in the mouth, but also an ecthymatous eruption on the body, an attack of erysipelas of the scalp caused the disappearance of all syphilitic symptoms.

M. Mauriac does not, however, contend that this effect of erysipelas is more than temporary, and he adds in conclusion that the development of this disease is not always a favorable omen for the cure or amelioration of cutaneous syphilitic manifestations. It may, on the contrary, become an aggravating circumstance, when the disease takes a malignant form or has arrived at a cachectic stage.—*L'Union Méd.*, No. 14, 1874. A. V. H.

Influence of Cerebral Lesions on the Lungs.—*L'Union Médicale*, No. 14, 1874, contains an abstract of a paper by M. Aug. Ollivier on the production of hemorrhages and other affections of the lungs consequent on cerebral lesions. His observations showed congestion more or less intense, with occasional sanguineous effusion into the pleura and apoplectic centres, either scattered through the entire lung or showing themselves at various points.

These alterations were observed to occur in the lung corresponding to the hemiplegic side, and occurred more frequently following a cerebral lesion located at the base of the brain or influencing it, whether this lesion were hemorrhage, tumor, or softening.

M. Ollivier is disposed to attribute the cause of these lesions to a vaso-motor paralysis, and classes them with the vascularity of the skin and elevated temperature on the affected side which are observed in similar cases. A. V. H.

Hydrate of Chloral and Morphia in Eclampsia.—Dr. Condereau, in a letter recently published in the *Bull. Gén. de Thérapeutique*, relates two cases occurring under his observation in which the combination of these remedies was found very satisfactory.

The first was that of a woman 23 years of age, attacked at the end of her first pregnancy by convulsions. Hydrate of chloral alone in the dose of one drachm had proved of no avail, when the addition of a hypodermic injection of three-fourths of a grain of muriate of morphia, succeeded in a few minutes by thirty grains more of the chloral, was followed by almost immediate relaxation without return of the convulsions.

The second case was that of a man 24 years of age, who had been subject to occasional but severe epileptic attacks, accompanied by furious mania, sometimes lasting for days. The hydrate of chloral had been used in this case, also alone, but was not found effectual until combined with a hypodermic injection of the muriate of morphia. The dose of the latter was, as in the other case, three-fourths of a grain, followed in a few moments by a drachm and a half of chloral hydrate. The result was very satisfactory, the convulsions being almost entirely controlled. A. V. H.

PHILADELPHIA
MEDICAL TIMES.
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The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

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EDITORIAL.

WANTED—AID BY A DISTRESSED COMMUNITY.

WE are thorough believers in the power of women: in their weakness, or rather by their weakness, they move the world for good or for evil as the case may be. The life-long training of the housewife of course fits her to see at once in public institutions faults as to cleanliness, cooking, waste, etc., which are only detected with difficulty by the average man, or more often altogether escape his inspection. Far more important attributes in fitting ladies for the work of supervising hospitals are a peculiar moral fitness, and in most cases an endless supply of leisure. The possession of the latter is of itself a necessity for success to the would-be reformer; and how seldom can men of prominence in this country boast that they are rich in this needed commodity! With a naturally quick sympathy which when fairly aroused dominates everything,—with a power of self-sacrifice that is very rarely possessed by the sterner sex,—with a gentle persistency which no rebuff daunts and which no obstacles can successfully resist,—no wonder woman often is to the poor wretches in the hospitals and almshouses as an angel from heaven, acting in a quieter sphere the rôle of a Florence Nightingale, and exercising, perhaps in an almost equal degree, those qualities which have filled the world with her renown. There is one institution in this city which we believe to be beyond the power of man to improve,—an institution which, while it might be deemed a wonder of charity in Dahomey, is in a Christian community a standing disgrace. The readers of our columns need scarcely be told that we refer to the Philadelphia Hospital. The only hope of reform seems to us to lie in a visiting committee of ladies who are socially of such standing as to give weight to their words,—morally of such calibre that they will not flee from appalling scenes of suffering or of neglect, but be nerved by them to persistent efforts,—physically of sufficient presence to withstand the bodily labor and the tax that sympathy lays. Under the periodic visitation of such a committee we believe very much would be accomplished in a very short time. Why some of the active spirits so prominent upon anti-vivisecting and other committees for the protection of the "higher animals" cannot stoop to aid the poor unfortunates of their own kind, we cannot tell. We can only pray that a morsel of the energy and effort put forth may fall to Lazarus. We have thought that Bellevue Hospital, New York, alongside of our Philadelphia Hospital, is a monument of mercy, a paradise among hospitals: yet the visiting committee there is doing wonders, if we may believe a writer who seems to know what he is speaking about. He says (*N. Y. Tribune*, March 26),—

"First, then, be it said, that Bellevue Hospital, though without soap during two weeks in January; though at times three patients have slept on two beds, five patients on three beds, and many have slept on the floor without blankets and pillows; though in the lying-in wards during January there were no towels, and not a sufficient supply of clothing to keep babies and mothers clean,—though all these things have been, Bellevue Hospital is in a more seemly condition than ever before, and, thanks to the Training School for Nurses, takes better care of its sick. So radically has it been reformed that, in spite of official opposition, it promises to be reformed altogether."

Why cannot official opposition and official inertia be met here by a visiting committee?

THE touching solicitude shown by the members of our Obstetrical Society to educate New York up to its own high standard is something truly remarkable; especially since it is not generally supposed that New York needs such instruction. Unless we are wrongly informed, some very good works on that branch of medical science have from time to time appeared from the pens of New York physicians, and it would seem difficult even by flooding them with the Society's papers to make

them acknowledge their own inferiority. Can it be that the learned Society, when by its researches it has brought forth some new and valuable matter, fears to impart it to its neighbors, "lest they become as gods" also, and chooses rather to lose its work in the busy whirl of the Western metropolis, as he who, made wretched by the possession of unwonted riches, sinks them in the ocean to relieve his mind of care?

It seems strange that while we have a journal acknowledged to be fully alive, and representing as none other does the talent and worth of our schools, its pages should not be allowed to present any record of the meetings and transactions, the papers and debates, of one of our principal societies. Is the learned body bound hand and foot by the Manhattan Delilah?

"Down the river did glide, with wind and with tide,
A pig with vast sobriety;
And the devil looked wise as he saw how the while
It cut its own throat. 'There,' quoth he with a smile,
'Goes Philadelphia's Obstetric Society.'"

SOME weeks since, in a book-notice, we took occasion to anathematize the American habit of pirating English books. This has given origin to the letter printed below. We did not say that the book was pirated, but only stated that it had the appearance of having been so. We are very glad to see that constant dropping has worn away stone; that under the steady fire of the medical press the publishers are beginning to acknowledge that even authors have rights; and we sincerely trust that the habit of stealing other men's property will soon be a thing purely of the past.

11 New Burlington Street, London, W.
17th March, 1874.

To the Editor of the Philadelphia Medical Times:

Sir,—We are glad to be able to inform you that the American reprint of "Lectures on the Clinical Uses of Electricity," by J. Russell Reynolds, reviewed in your number of 28th of February, is not, as you fear, a pirated edition, but has been published by Messrs. Lindsay & Blakiston under an arrangement satisfactory both to the author and to

Your obedient servants,
J. & A. Churchill,
Publishers in England of the said work.

WE see by the Annual Report of the Episcopal Hospital that a contract was entered into last summer for the erection of the east wing of the building at a cost of $111,500, and that the foundation-walls of the building are all finished. Of the required amount $61,000 have been already subscribed, leaving $80,000 still to be raised for the completion and furnishing of the wing. Situated in a distant and formerly neglected part of the city, among a population probably needing hospital accommodation more than any other of our city, this institution has done an excellent work, and we trust that it will be liberally furnished with all that it needs to enter upon a career of increased usefulness.

THE old civilization of the British Islands does not seem to differ very much from the newer civilization of this country, in that it considers killing no murder, provided it be done by quacks. Thus, we learn from the London *Lancet* of March 14 that a roadside "professor" who killed a young man by giving a fatal dose of arsenic for a cough was, after conviction, sentenced "to three months' imprisonment, without hard labor." The extenuating circumstance in the case, which produced this trifling sentence, was, that the professor did not know arsenic was so poisonous.

PROCEEDINGS OF SOCIETIES.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

A CONVERSATIONAL meeting was held December 24, 1873, at 8 o'clock P.M.

Dr. Edward Wallace was called to the chair.

Dr. M. O'Hara read the report of a case of successful tracheotomy. (See current number of the *Times*.)

Dr. J. S. Cohen stated that he had seen the case of Dr. O'Hara several times since the operation, and was in some doubt as to whether it were not a case of acute laryngitis of children, with submucous organizable effusion, resting this opinion on the absence of any evidence of membrane, the tenderness externally, the immediate recuperation after the operation, the impossibility of respiration without the tube for so long a time, and the swollen condition of the upper portion of the larynx which had prevented laryngoscopic inspection of the interior. He had no doubt as to the propriety of the operation, and believed that cases of simple inflammatory laryngitis were not relieved from suffocation by tracheotomy, because they were mistaken for croup, which many think impossible to overcome by the operation. Persons who have been unfortunate in their first few tracheotomies for croup were too apt to abandon the operation, yet several prominent tracheotomists had lost numbers of cases before they had succeeded in saving one, but still they persisted; and, as the result of several hundred operations, their success had reached the average proportion. He had referred to the retention of the tube. In some undoubted cases of croup there had been, for various reasons, an impossibility to breathe without the tube, though in most instances it could be removed from the fifth to the ninth day, and, exceptionally, much earlier.

The operation should be performed early, before the blood was poisoned by the retained carbonic acid; but cases had been saved at the last extremity. Continuous and increasing dyspnœa with sub-thoracic inspiratory sinking-in, would, he believed, indicate the time for operation, provided these symptoms had existed two or three hours, or even only an hour, and remained insusceptible to the ordinary modes of relief. When the propriety of the operation suggested itself for the first time, there was little time to lose; too long a delay might compromise the result. He believed a great deal of success depended on the after-treatment. The patient, his disease, and for the first day or two his tube, particularly, needed attention. He believed that the surgeon, or a competent and responsible medical representative, should stay by the patient the first night after the operation; and, in some cases, the second night also. Cases are sometimes lost by allowing the tube to become stopped up, and the patient dies in the very condition for the relief of which the operation was instituted. He was not prepared to assert that these patients would have lived if the after-attention had been everything that could be desired; but he did believe that they did not obtain a fair chance for their lives. With regard to the statistics on the subject, it was hard to get much satisfaction from them, except that cases were saved; and Dr. Cohen said that he was of the opinion of those who were satisfied with this fact, without inquiring as to the proportionate number saved. The published statistics of the Parisian hospitals, and of many private operators who had reported their unsuccessful as well as their successful cases,—now amounting to thousands,—show a proportionate saving of one in from three to four cases. Individual records must be taken at their individual worth. He believed with Trousseau that, with proper care and attention, at least one-half of the cases suitable for operation ought to be saved in private practice.

Dr. H. Lenox Hodge said that he was much interested in the subject which Dr. O'Hara had brought before the Society in his carefully-prepared paper full of pointed thought in regard to his case and the operation.

Dr. O'Hara asked the question whether an anæsthetic should be used.

Dr. Hodge remarked that while he employs anæsthetics in almost every other operation in surgery, he does not use them in tracheotomy. When the trachea is first opened, there is, for a few moments, almost a cessation of respiration; and not unfrequently artificial respiration has to be resorted to. For this reason the child should be in the best possible condition to respond to the surgeon's efforts, and not unconscious from an anæsthetic. The child does not suffer much pain, as the impeded respiration has long since lessened his sensibilities. Dr. Hodge recommends that a portion of two or three rings of the trachea be excised, as has been done in this city for a number of years by Professor Pancoast. In addition to this, Dr. H. employs the tracheal tube for a few days. When such a section of the trachea has been made, the tube is easily inserted without a director, may be removed without any danger of impairing respiration, and can easily be replaced. Dr. H. referred to one case of membranous croup, in which the child would have died if it had not been for this section. In a paroxysm of cough and apnœa, with the tube in place, death was imminent; the tube was withdrawn, and a mass of membranes discharged through the section which could scarcely be forced afterwards through the tube. Some have objected to the section of a segment of the trachea, that in after-years the scar, by contracting, would interfere with the respiration and the voice. Experience has shown that this does not result in the least degree. By the operation many lives may be saved which otherwise would be lost; and even when life is not saved, relief is given to the terrible dyspnœa.

Dr. Hodge reported four cases of tracheotomy on account of membranous croup; and of these four, three lives were saved. He would recommend that the trachea be opened just beneath the isthmus of the thyroid gland, as high as possible without injury to the gland blood-vessels; that a segment of the trachea be excised, and that the patient be kept for a long time in a moist atmosphere at a temperature of 80° Fahr.

Dr. P. D. Keyser asked what kind of canula the gentleman used. He had seen a flexible tube used in Berlin and Paris which did not produce friction and irritation in the trachea. Cases have died after the operation, from tracheitis, produced by the use of an inflexible instrument.

Dr. Hodge, in reply to Dr. Keyser, said that cases had been reported in which the tracheal tube had produced ulceration even into the innominate artery. One advantage of the operation as above recommended was, that the tube could soon be dispensed with.

REVIEWS AND BOOK NOTICES.

The Puerperal Diseases. Clinical Lectures delivered at Bellevue Hospital. By Fordyce Barker, M.D. New York, D. Appleton & Co., 1874.

We confess to a weakness for a good clinical lecture, whether delivered to the listeners of the amphitheatre or through the press to the listening world. Since we read, with a rapture that time has somewhat toned, the "Lectures on the Renewal of Life," no book of the kind has pleased us more than "The Puerperal Diseases." The happy union of the clinical and didactic, the extreme fitness of the well-selected cases to the remarks, and of the remarks to the cases, the excellent note-taking in the cases, and the author's clear statement of his own opinions,—a clearness not at all dogmatic,—give a life and reality to the work which impress us with confidence in its truth.

The scope of the work is not too wide, not too limited; everything is not crowded upon us in clinical form, like a polypharmic pill which hopes to pass unnoticed by its silver coating. The diseases treated are all well bound together by a strong natural union,—the puerperal state; all bring us in their study to the bedside of the newly-delivered woman,—nowhere else. They can, from their limited number, be remembered as a whole in their various relations and connections. The book has a being and an entity: like a poem, it evidently grew, was not made.

The author claims that this is the only work of the kind in the English language: it is the digest of nearly twenty years of clinical teaching in Bellevue Hospital, made up from phonographic reports, condensed and brought up to the standard of the times.

Lecture I. treats of puerperal convalescence, and contains many practical suggestions. The author, however, recommends placing the patient upon the hands and knees where the bladder cannot be emptied in the recumbent position after labor, which we hardly think entirely sound advice. To say nothing of the danger from hemorrhage, the risk of the entrance of air into the vagina and uterus has been lately pointed out as being much greater in this position than in any other. Generally, we think, the secret lies in an early attempt, and in never allowing the patient to entertain the idea of there being any difficulty in the recumbent position, and enjoining upon the nurse to make moderate pressure over the pubis during the

effort. Should this fail, we think the catheter preferable to the posture mentioned above.

In retention from over-distention, the author uses ergot in fifteen-drop doses, often repeated; but many of these cases have already taken ergot in much larger doses shortly before, and in fact it has been claimed that ergot favors retention.

On page 8 the author speaks—in treating of after-pains—of "certain rare cases purely neuralgic," where the uterus is small, firm, but exquisitely sensitive to pressure; cases which do not yield to opiates, but are successfully treated by full doses of quinia and chloroform liniment applied externally. This suggestion we consider of great value. He also employs vaginal injections of dilute carbolic acid in all his private puerperal patients for the first few days: why not also in his hospital practice we fail to understand, where, if ever, their use seems specially indicated.

Where purulent leucorrhœa succeeds the cessation of the lochia we are advised to make immediate examination with the speculum, the author expecting in such cases to discover erosion of the cervix, and by treatment greatly to hasten convalescence.

For delayed involution he recommends ergot, nux vomica, and tinct. ferri chl., using the tincture of nux vomica in the somewhat large dose of fifteen minims or about thirty drops, which seems to us liable to affect the nursing infant when repeated several times a day.

On page 18, treating of secondary hemorrhage, after injecting dilute persulphate of iron, of the use of which he is a strong advocate, he says, "If your patient shows no signs of shock from loss of blood, give thirty drops of Squibb's fluid extract of ergot with twenty drops of the tincture of nux vomica;" and a little farther on, "If the patient exhibit shock from loss of blood, do not give ergot till the reaction is established." In these sentences the author gives either very valuable or very dangerous advice, and the question hinges upon the fact whether we have any proof that ergot increases shock, for we have proof that it is very efficient in preventing hemorrhage, and unless there be certainly danger from its administration under the circumstances its delay is dangerous. The question in our present state of knowledge is a difficult one. If ergot, as many believe, causes contraction of the vessels of the spinal cord, and if the resulting anæmia of the cord tends to deepen or prolong the condition known as shock, then its administration may do more harm than the good to be expected from its action on the uterine fibres.

While he warns against leaving fragments of placenta and membranes in the uterus, we do not see that the author has anywhere laid stress upon the necessity of a careful examination of the removed secundines, which so often would tell their own story.

Where portions of placenta have been unavoidably retained, and hemorrhage results, the advice given is, if the os be firm and contracted, to tampon the cervix with sponge-tent, and apply a pad and binder firmly over the uterus, though it is admitted that patients have died of accumulation of blood in its cavity "two, three, and four weeks after parturition." After dilatation by the tent, in six or eight hours he attempts removal of the offending body, and, if successful, injects the cavity with persulphate in dilute solution. Where the os is flaccid, the injection alone is recommended, and in either case he administers a rectal enema of an ounce of turpentine with half an ounce of olive oil. In this connection ergot is not noticed, though we cannot but think its administration would be as useful as the pad and binder.

Lecture II. is upon the diet of puerperal women. The author is an enemy of restricted diet. No parturient Oliver would need to ask him for more. He administers beef-tea early, and full diet as soon as appetite demands it. He finds nurses unwilling at first, but growing rapidly enthusiastic; which we take it is one of the main dangers of the liberal system, and confess we are still in favor of moderate restriction for the first few days.

On page 29 we find some valuable hints about the use of purgatives. The tendency of castor oil to bring down and aggravate hemorrhoids is noticed. Where these exist, the author recommends either an aloetic pill or a liquid preparation of senna, jalap, and nux vomica. For the cure of painful piles the author relies upon small doses of aloes, combating the idea that they aggravate this condition in puerperal women. Forcible dilatation of the sphincter ani—after the method of Van Buren—he considers the best procedure where they are developed during labor, selecting the moment after the birth of the child and before removal of the placenta.

Lecture III. treats of laceration of the perineum. In regard to support of this structure, the view of the author (p. 46) is, "that he is confident that a majority of lacerations under his own notice have occurred from the patients suddenly withdrawing themselves from the supporting hand," evidently favoring support; while, however, he subsequently states that the term "support" is an unfortunate one, and closes the chapter by quoting largely from the paper of Dr. William Goodell on this subject.

Lecture IV. treats of thrombus of the vulva and vagina; Lecture V. of puerperal albuminuria. This chapter and the two following on puerperal convulsions are illustrated by remarkably striking and pertinent cases. The author's experience has been extended, and his opinions are decided. He considers that the albuminuria discovered after convulsions have occurred is more often the effect than the cause of the convulsions, yet does not deny the danger of pre-existing albuminuria, as on page 114, when speaking of its treatment, he says, "I can truly affirm that I now rarely encounter puerperal convulsions when the previous detection of albuminuria has led me to be particularly apprehensive of their occurrence. Indeed, I will go further, and say that in most cases where any of the predisposing causes that I have mentioned are discovered sufficiently early, they may be successfully treated, and convulsions will occur only in a small percentage."

The view of the author seems to be that both convulsions and pre-existing albuminuria are manifestations of some existing morbid cause, probably (page 110) "the highly congested state of the venous system." On page 112 he gives the following as the predisposing causes of convulsions: "albuminuria, hydræmia, anæmia, uræmia, and primiparity," and adds "hereditary and atmospheric influence."

In the treatment of convulsions occurring before labor, bleeding is recommended if the pulse be full and hard, and evidences of cerebral congestion apparent: he then gives a brisk purgative, preferring elaterium if the patient be comatose, calomel and jalap if not. He avoids stimulating enemata, and endeavors to arrest the convulsions by inhalations of chloroform, suspending it during the attacks, unless the intervals be very short; and, to prevent a return, the hypodermic injection of morphia in full doses. The alleged danger of fatal narcotism from renal lesions he considers more imaginary than real. He considers it—the morphia—"the most efficient means yet known for allaying that irritation of the spinal system which culminates in convulsions, and that uræmia does not contra-indicate the use of this agent."

Chloral hydrate he has not found serviceable. Where "delivery irritates less than delay," he delivers. After labor, the question of bleeding resolves itself somewhat into how much blood has already been lost: if less

than usual, the author advises bleeding, elaterium, and diuretics. If the patient be anæmic and exhausted, he would use morphia, but no chloroform.

Lecture VIII., on Lactation, we recommend to the reader for its excellent treatment of the management of sore nipples. Recognizing that there are sore nipples, the author endeavors rationally to discriminate in their treatment. One sentence we light on, p. 137, which is worth more than many books: "If the ulcerative process have commenced, stop nursing from that nipple." How much suffering and consequent destruction of health would be avoided were this plain precept always put in practice! The author advises, as a lotion preventive of erosion and excoriation, a ten-grain solution of the nitrate of lead. It has been vaunted as a remedy rather than a preventive, and as a remedy we have met with but indifferent success with it. We would remark that where the solution has failed, cure has followed the use of the powdered nitrate dusted upon the excoriated surface.

The chapter on Mastitis and Mammary Abscess aims also at a clear discrimination of the varieties of the complaint. The author does not consider belladonna, however early and freely used, as capable of arresting the formation of pus. He seems a little doubtful even of its power in arresting the secretion of milk.

Puerperal Mania, Relaxation of Pelvic Symphysis, and Phlegmasia Dolens, are the subjects of the three succeeding chapters. The remainder of the book is taken up principally with that group of diseases sometimes included under the general head of puerperal fever, which the author, however, considers a distinct zymotic disease.

On p. 476 he sums up his opinions in a distinct "confession of faith," the points of which briefly are, that it is a fever peculiar to puerperal women,—its symptoms not the consequence of local lesion; it is of the class known as zymotic; we are ignorant of its specific cause, which "may be either epidemic influence, contagion, infection, or probably nosocomial malaria;" that death may occur without any local lesion sufficient to account for it, and that while erysipelas, scarlatina, etc., may develop puerperal erysipelas, puerperal scarlatina, etc., they cannot cause true puerperal fever. In accordance with such views, we find puerperal peritonitis, pyæmia, and septicæmia treated of as distinct affections. Space and time fail to allow us a detailed account of these valuable chapters. The author's argument, to some not convincing, must to all seem able and candid; while the views of others are stated with fairness. He advises strongly the employment of veratrum viride in puerperal fever and peritonitis; and the employment of full doses of quinia in these groups of diseases.

Much has been said of the practical element in the American character, and, while in its medical literature this has been too often another name for shiftlessness and mechanical performances, we are glad to point to the present work as one eminently and truly practical. Clinical lectures most often fail when we attempt to apply their teachings to actual practice. The lines of demarcation, so sharply drawn in the lecture or the book, vanish at the bedside; disease complicates disease, till the student longs in vain to meet one of those typical cases that he knows all about, but which seem to flourish only on paper or in the hospital atmosphere. Few books of the kind will stand this test, but, if we mistake not, this is one of the few.

E. W. W.

A Clinical History of the Medical and Surgical Diseases of Women. By Robert Barnes, M.D. Lond. Philadelphia, H. C. Lea.

The author of "Obstetric Operations" has already made himself the friend of many a *distrait* brother in the profession, and the rare charm of that work is not wanting in the present volume. He aims, not at a mere compilation of the works of others, but to draw largely from his own experience and "to bring into the circle of gynæcological literature new illustrations:" of his success in this endeavor the reader must judge for himself.

The volume before us—the American edition, published by Henry C. Lea—contains nearly eight hundred pages, with one hundred and sixty-nine engravings on wood, very many of them original with the present work. The chapters are full, thorough, and well written; the evident aim throughout the book being the sometimes forgotten one—to teach how to cure or palliate disease. There is no show of erudition, no overwhelming citation of authorities to display the extent of the author's reading, but he leaves it for the reader to judge whether he be familiar with them or not.

The violent rider of no hobbies, its author is a man of decided and original views, which the critic may at times dissent from, but can by no means despise.

An extended review of this book is not our intention, but we may say that a careful perusal has discovered to us but slight grounds for fault-finding; and while comparisons are odious, the reader will not be disappointed even though he take up the book with a very exalted idea of its merits.

GLEANINGS FROM OUR EXCHANGES.

Ichthyosis Linguæ (*The Lancet*, March 14, 1874).—At a meeting of the Royal Medical and Chirurgical Society Mr. W. Fairlie Clark read a paper on this disease. According to him, it manifests itself in an overgrowth of the papillary and epithelial elements of the mucous membrane, and it is the dorsum of the tongue which is affected in the majority of instances. In some cases the enlarged papillæ may be seen sprouting up in small groups, in others the whole of the affected surface is smooth, hard, and almost cartilaginous. It presents either a silvery or a snow-white appearance, quite different from any fur which ordinarily covers the tongue. When the disease has once manifested itself, it is very persistent. Though it sometimes responds a little to treatment, and though it varies slightly, it never wholly leaves a spot which it has once attacked.

It may be distinguished both pathologically and clinically from warts, corns, and papillary tumors of the gum, in two ways. 1. It attacks only the tongue and the inside of the mouth; no other mucous membrane is subject to such an affection. 2. It slowly spreads, but gives only slight inconvenience and no pain. In this state it may remain many years, but sooner or later it assumes the characters of epithelial cancer. Its essential nature appears to be that of a chronic inflammation, accompanied by an overgrowth of the papillæ and a loss of power to throw off the effete epithelium. It is much more common in men than in women, and never occurs before puberty. A venereal ulceration may be its starting-point, but there is no reason to think that it is always associated with syphilis. If the disease presents itself in a very early stage, it should be promptly and thoroughly excised. On the other hand, when it has become epitheliomatous, no time should be lost in performing an operation. But during the whole middle period the best thing that can be done for the patient is to study his general health. If any local measures are used, they should be of an unirritating kind. If any jagged teeth are present, they should be removed. At the same time, the patient should be advised to guard his tongue against all

sources of irritation, and to pay particular attention to his digestion. Under this treatment the ichthyotic coating often alters for the better, though it is never altogether removed.

ACUTE PERIOSTITIS OF THE OCCIPUT AND UPPER CERVICAL VERTEBRÆ (*Boston Medical and Surgical Journal*, March 19, 1874).—George Atwood, M.D., reports the case of a stout, healthy man, æt. 50, in whom an erysipelatous inflammation of the face and neck was followed in about a month by severe pain which seemed at first to be neuralgic, but soon developed alarming characters. There were frequently-recurring spasms of the neck; the muscles were rigid; the jaw was tightly closed; the patient could only take liquids, and these, on being swallowed, excited spasms; he could not lie down in bed, for immediately on making the attempt spasmodic action would follow, so as to render the act impossible. On moving the head, pain would commence in the neck, and extend upward over the back of the head, and downward to the shoulders, but never any farther. The pulse was 95, and at times intermitting. During the next four weeks he did not lie in bed, but slept in a chair when he was not walking the room.

He was placed on iodide of potassium, bromides, cod-liver oil, strychnia,—with tincture of iodine, blisters, and counter-irritation to the neck,—and obtained some relief, which was, however, only temporary. A month or two later, he had a paralytic attack, and three months from the commencement of his troubles he expired suddenly.

On dissection, the condyles of the occiput, both articulating surfaces of the atlas, the axis, and the odontoid process were denuded and eroded, the latter feeling smooth and like a piece of ivory. No induration of the tissues, and no effusion of pus or lymph, was apparent; but the periosteum and ligaments around the spine, and on the base of the occiput, to the extent of an inch from the foramen magnum, could be easily torn; the softening being more marked on the left side than upon the right, although the tissues generally were of a dull red color and softened. The transverse ligament connected with the odontoid process was destroyed, and mobility of the head was quite free.

LARGE DOSES OF BROMIDE OF POTASSIUM IN EPILEPSY (*The Lancet*, March 14, 1874).—Dr. Ottley reports a case of severe epileptic convulsions occurring in a man aged 21. For two days he was never three hours at a time without a paroxysm, and they increased in frequency and violence until he had five in twenty-five minutes. Respiration was accelerated, and the patient was comatose and almost hemiplegic. He was then ordered twenty grains of bromide of potassium every hour. In half an hour the fits were less frequent, an interval of four hours then occurred without any convulsion, and nine hours after the administration of the first dose he had his final paroxysm. He continued to improve in every particular. On the following day the bromide was decreased to twenty grains every four hours, and then gradually lowered to twenty grains three times a day, which dose he was ordered to continue for a twelve-month.

BROMIDE OF POTASSIUM IN EPILEPSY (*The Dublin Journal of Medical Science*, February, 1874).—At a meeting of the Medical Society of the College of Physicians, Mr. Thomas Hayden read a paper on the use of bromide of potassium in epilepsy, and gave three cases, in all of which a marked amelioration in the condition of the patients had resulted, though it could not be asserted that they were completely cured. He found the full benefit of the salt could be obtained by giving thirty grains thrice daily, and the only symptoms of bromism caused by this dose were vertigo, indistinct articulation, and an unsteady, tottering gait. He believes the efficacy of the drug to be limited to a reduction in the number of the fits and a mitigation in their severity, while at the same time the nutrition of the nerve-centres is promoted, as judged by the improvement of memory and of self-confidence, and the cessation of muscular tremor on the part of the patient. He could not agree with Dr. Darby, who had tried bromide of ammonium with young females, and had obtained more favorable results than from the use of the potassium salt. He thought, on the contrary, that it was precisely and especially in cases of epilepsy associated with uterine derangements that the bromide of potassium was efficacious and the bromide of ammonium not so. Dr. Fitzpatrick had found the most benefit from its use in the minor form of the disease, in those cases which merely occurred during sleep, or which were dependent on uterine irregularities in the female, or on seminal irritation in the male.

A RAPID CURE FOR TAPE-WORM.—A. J. Schafish, of Washington, says, *inter alia*: I made no preliminary provisions further than to forbid the patient from taking any breakfast the day I intended removing the worm, and giving him a large dose of Rochelle salts the preceding night. At ten o'clock in the morning he had the following at one dose:

℞ Bark of pomegranate root, ½ ounce;
Pumpkin-seed, ½ drachm;
Ethereal extract of male fern, 1 drachm;
Powdered ergot, ½ drachm;
Powdered gum arabic, 2 drachms;
Croton oil, 2 drops.

The pomegranate-bark and pumpkin-seed were thoroughly bruised, and, with the ergot, boiled in eight ounces of water for fifteen minutes, then strained through a coarse cloth. The croton oil was first well rubbed up with the acacia and extract of male fern, and then formed into an emulsion with the decoction. In each case the worm was expelled alive and entire within two hours. No unpleasant effects followed.

One curious fact that I have noticed is that in each case the worm was passed with the head firmly fastened to the side of its body at about the widest part, from which it was with difficulty removed; also that the worm was twisted and doubled into various knots. In one specimen, only fourteen feet long, I have counted and untied no less than forty-seven of such knots. I have no doubt that, to escape the effects of the medicine, in his distress, he fastens himself to his own body, in this way loosing his hold of the intestines, and is driven forward with the other contents of the bowels.—*The Druggist's Circular.*

REST AS A THERAPEUTIC AGENT (*The Dublin Journal of Medical Science*, February, 1874).—Dr. J. Magee Finney, under the above title, has written an interesting paper detailing a number of cases occurring in his practice, some of which illustrate the importance of physical and physiological rest as a curative means. He alludes to the hygienic and therapeutic importance of the law that, in the recovery from any illness, long or short, exercise, to be beneficial, must be accurately proportioned to the strength of the individual, and must never be carried to the extent of actual fatigue or temporary exhaustion. In cardiac diseases rest is particularly important, and in dilatation, pericardial inflammation, and stenosis or patency of the mitral orifice it is imperatively demanded. In the treatment of internal aneurism, rest affords the best possible means of placing the patient on the way to nature's cure.

FRACTURE OF THE CLAVICLE TREATED BY PLACING THE ARM BEHIND THE BACK (*Edinburgh Medical*

Journal, February, 1874).—M. Broca recently healed a case of fracture of the left clavicle, in which the fracture was near the middle of the bone, and was oblique from above downwards and from without inwards, the fragments riding one another considerably. After numerous plans of treatment had failed to reduce the fragments, he placed the arm in a semi-flexed position behind the back, where it was retained by a bandage for eighteen days, with the effect of completely adjusting the fractured surface, and producing an excellent cure. For a few days longer a sling was used. The patient, a man of considerable nerve, complained of the pain and inconvenience of the method only the first twenty-four hours.

BILLROTH'S OPERATION FOR REMOVAL OF THE WHOLE LARYNX.—The patient was exhibited to the Imperial Medical Society of Vienna. The operation had been performed some time previously, and, thanks to a very ingenious apparatus, the man was enabled to speak and swallow. Many contrivances were tried before the successful one, which consisted principally of two curved canulæ, to which were added a tracheatube and a voice-canula. The apparatus for phonation was supplied with a peculiar kind of tongue made of very thin silver. The patient was desired to read aloud before the members of the Society, and, though he spoke pretty distinctly, great attention was required to follow him. The poor man looked very thin and anæmic, and it was feared that carcinoma would ere long break out in other parts of his frame. Billroth's operation remains, nevertheless, a great surgical feat.—*London Lancet.*

MISCELLANY.

AT a meeting of the board of trustees, April 7, Dr. Wm. H. Pancoast was elected to the position of Professor of Anatomy in the Jefferson Medical College, on the fifteenth ballot.

NEW YORK HOSPITAL.—The Governors of the New York Hospital have purchased the "Thorne" mansion in West Sixteenth Street. The house is about 66 by 80 feet, and three stories in height. In the rear of this the Special Committee recommend the erection of a reception-hospital for acute surgical and medical cases, with a capacity of from 50 to 90 beds. They estimate the cost of the hospital building at $170,000, of its furniture at $20,000, and of the engine-house, laundry, and vaults at $30,000. The probable yearly expenses of the reception-hospital were estimated at about $40,000. The recommendations of the committee were unanimously adopted by the Board of Governors, and the Thorne property was secured for $20,000. The first floor of the house will be used for offices; the second for the library and pathological cabinet; the third floor for the hospital staff, and probably some private wards. Possession will probably be obtained about April 1. Additional ground in the vicinity will probably be obtained.—*Tribune*, March 18.

A BIT OF EXPERT-TESTIMONY.—When Orfila, the celebrated French chemist, was on one occasion a witness at a trial for poisoning, he was asked by the president if he could state the quantity of arsenic requisite to kill a fly. "Certainly, M. le Président," replied the expert; "but I must know beforehand the age of the fly, its sex, its temperament, its condition and habits of body, whether married or single, widow or maiden, widower or bachelor."—*Boston Journal of Chemistry.*

HONORS TO TRAUBE.—On January 25, Prof. Traube ended his twenty-fifth year of service at the Berlin Charité. In consideration of the character of this service, the directors of the hospital gave a celebration dinner, at which most of the professors of the University, and many other physicians, were honored guests. —*Wiener Med. Presse*, February 15, 1874.—*Clinic.*

THE English pharmaceutical chemist, Thomas N. R. Morson, died on the 3d of March last, from paralysis, in the seventy-fifth year of his age. He was the first man who manufactured the sulphates of quinia and of morphia in England.

A YORKSHIRE PRESCRIPTION.—

"Too pennorth Oil of Vermins
Wan pennorth Seraph of Eyelets
Wan pennorth Seraph of Squeels."

NOTES AND QUERIES.

DR. HASSALL has recently analyzed nineteen samples of sherry wine,—eight of them of the highest quality procurable in the London market. Not one of them could be considered as a pure and natural product of the grape; all of them had been heavily fortified by the addition of spirit, and seventeen of them contained a notable amount of the sulphate of calcium.

AT a stated meeting of the College of Physicians of Philadelphia, held April 1, 1874, Prof. Gross announced the death of Prof. Henry Miller, of Louisville, Ky., and offered the following preamble and resolutions, which were adopted:

"*Whereas*, The College of Physicians of Philadelphia has heard with profound regret of the death of Prof. Henry Miller, M.D., of Louisville, Kentucky, an Associate of this College; and whereas, it is meet and proper, when a great and a good man dies, that his surviving friends should record their opinion and feelings of his worth; therefore, be it

"*Resolved*, That in the death of Dr. Henry Miller, for nearly a third of a century Professor of Midwifery, first in the University of Louisville, and afterwards in the Louisville Medical College, medical science has lost one of its most zealous votaries, obstetric medicine one of its most instructive and lucid expounders, and American authorship one of its most able and distinguished writers.

"*Resolved*, That a minute of these proceedings be recorded upon the books of this College, as a mark of our appreciation of the worth of our deceased associate; that a notice of them be published in the medical journals of this city, and also that the Secretary be instructed to send a copy of them to the family of the late Professor Miller, with the assurance of our heartfelt sympathy in their bereavement."

JOHN H. PACKARD,
Secretary.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM MARCH 31, 1874, TO APRIL 6, 1874, INCLUSIVE.

PETERS, D. C., SURGEON.—Granted leave of absence for sixty days, on Surgeon's Certificate of Disability, with permission to leave limits of the Division. S. O. 8, Division of the South, March 31, 1874.

HALL, J. D., ASSISTANT-SURGEON.—Granted leave of absence for thirty days, to take effect when a relieving officer shall have reported at Fort Benton. S. O. 56, c. s., Department of Dakota.